

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05253
15249
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 35 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 252 ELDER STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last BERNICE K. ABE				4. DATE OF DEATH Month Day Year MAY 17 19 62											
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-1903		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Ownhome				11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN BUCKLEY				14. MOTHER'S MAIDEN NAME JANE ELIZABETH LOY											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 260X DUE TO (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous Cell Carcinoma of Cervix												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 4:18 P.M. , 19 62 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 4:25 A.M. , from the causes and on the date stated above.															
22a. SIGNATURE DR. LEWIS MOULD M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) DR. LEWIS MOULD				22d. ADDRESS 1068 NATIONAL HIGHWAY, LA VALE, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-20-62		23c. NAME OF CEMETERY OR CREMATORY Glebe Ro ut Cem.				23d. LOCATION (City, town or county) (State) Trough, W. Va.							
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md. ADDRESS						25a. REC'D BY REGISTRAR MAY 22 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Kline							



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THURSDAY

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IN CHARGE

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JOHN BUCKLEY

JOHN BUCKLEY

JOHN BUCKLEY - CONVICTION, 1941

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John Buckley

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05254 CERTIFICATE OF DEATH 05250

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 18 HRS.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CRESAPTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS Cresaptown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID WAYNE BARNCORD		4. DATE OF DEATH Month Day Year MAY 31 1962			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1962	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months Days Hours Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME OWEN K. BARNCORD		14. MOTHER'S MAIDEN NAME BARBARA WEAVER		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hydrocephalus DUE TO (c) Excision + Repair of Encephalocele		INTERVAL BETWEEN ONSET AND DEATH 18 hrs 3 Mos. 2 Mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-30-1962 to 5-31-1962 , that (I) was last saw the deceased alive on 5-31-1962 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE H. W. Eliason		M.D. DR. H. W. ELIASON		22b. DATE SIGNED 5-31-62	
22c. PHYSICIAN'S NAME (Type) DR. H. W. ELIASON		22d. ADDRESS 203 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/62		23c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery	
23d. LOCATION (City, town or county) La Vale, Maryland		23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer Cumberland, Maryland		ADDRESS John J. Hafer Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE SUN 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur J. House					

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CRIS WILSON

REMOVAL & REVISION WBS.
REMOVAL HOSPITAL

REMOVAL HOSPITAL

DAVID

WYATT

BRAND

WHITE

2-25-1965

CUMMINS, W. H.

GREEN K. SWINDELL

BARKER, DAVID

REMOVAL HOSPITAL - GREEN K. SWINDELL

DR. H. W. ELLISON

BOB GREEN, JR., GREEN K. SWINDELL

John L. Baker, Cumberland, Maryland

Removal Hospital, Allegany

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please send to the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

05255

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05251

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg d. STREET ADDRESS 1 65 Spring e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle HARVEY Last BITTNER		4. DATE OF DEATH Month 5 Day 6 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		11. BIRTHPLACE (State or foreign country) Wittenburg, Pa.	
13. FATHER'S NAME David Bittner		14. MOTHER'S MAIDEN NAME Sarah Ellen Shaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-7344	
17. INFORMANT Nevin D. Bittner, 51 Mill Street, Frostburg, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Femur DUE TO (c) 9 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. Fell in bedroom at his home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 4:00 a.m. Apr 28 19 62 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) his home	20f. (City or town) Frostburg (County) Allegany (State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W O McLane		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W O McLane MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF 5-9-62		Address (Street, city, town, or county) Frostburg, Md.	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg (State) Md.	
23. FUNERAL DIRECTOR Beulah H. Montross		24a. REC'D BY REGISTRAR MAY 11 '62	
23. FUNERAL HOME Hafer Funeral Home		24b. REGISTRAR'S SIGNATURE Clair S. Hines	
23. ADDRESS Frostburg, Md.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05256
05252

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in lb 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, Md. d. STREET ADDRESS R. F. D. 3 Nr. Lake Gordon e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JACOB Ervin BLUBAUGH		4. DATE OF DEATH Month Day Year MAY 8 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27, 1896
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	11. BIRTHPLACE (County & State, or foreign country) Charles Town, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME CHARLES BLUBAUGH	
14. MOTHER'S MAIDEN NAME IDA LANCASTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0 DUE TO (b) Anuria with uremia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Chemical pintaints Acute pancreatitis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bronchial asthma and pulmonary emphysema, Congestive Heart Failure			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-5-62 , 19 62 , to 5-8 , 19 62 , that (I) (we) last saw the deceased alive on 5-8 , 19 62 , and that death occurred 12:55 PM from the causes and on the date stated above.			
22a. SIGNATURE William P. James M.D.		22b. DATE SIGNED 5/9/62	
22c. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES		22d. ADDRESS 441 NORTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/62	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART H SPITAL						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STREET ADDRESS 206 FULTON STREET b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md d. STREET ADDRESS 206 Fulton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Donna Middle Gladys Last Bower			4. DATE OF DEATH Month 5 Day 18 Year 62			5. SEX Female			6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 23, 1911			9. AGE (In years last birthday) 50 yrs.			10. IF UNDER 1 YEAR Months 5 Days 18				
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			11b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Tucker County, near Aurora, W.Va.			12. CITIZEN OF WHAT COUNTRY U. S. A.				
13. FATHER'S NAME Shriver Stull						14. MOTHER'S MAIDEN NAME Annabelle Auvil							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Pt's Chart			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure - 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (b) Hypertensive + Arteriosclerotic Vascular Disease (c) Coarctation of the Aorta - above origin PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Arteries												INTERVAL BETWEEN ONSET AND DEATH Sudden 4 years 4 years life	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1958 to May 18, 1962 , that (I) (we) last saw the deceased alive on 4/15 19 62 , and that death occurred 7:15 PM , from the causes and on the date stated above.													
22a. SIGNATURE S. G. WEISMAN M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/18/62				
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN M.D.						22d. ADDRESS 59 GREENE ST CUMBERLAND, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/21/62			23c. NAME OF CEMETERY OR CREMATORY East Oak Grove Cemetery			23d. LOCATION (City, town or county) (State) Morgantown, West Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer						ADDRESS Cumberland, Maryland			25a. REC'D BY REGISTRAR DATE MAY 22 '62				
									25b. REGISTRAR'S SIGNATURE Arthur L. Hume				

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VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05258 CERTIFICATE OF DEATH 05254

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ADA Middle E. BRADIGAN Last			4. DATE OF DEATH Month MAY Day 26 Year 19 62		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1889	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
13. FATHER'S NAME LEWIS MOWRY			14. MOTHER'S MAIDEN NAME MARGARET LAFFERTY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma from Breast 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia					INTERVAL BETWEEN ONSET AND DEATH 3 yrs 4 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 19 , 19 62 , to MAY 26 , 19 62 , that (I) (we) last saw the deceased alive on MAY 26 , 19 62 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.					
22a. SIGNATURE William R. Wolverson M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/29/62
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM R. WOLVERTON			22d. ADDRESS 108 HARRISON STREET, CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE THEREOF 5/28/62	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Manns Choice, Penna
24. FUNERAL DIRECTOR'S SIGNATURE Harvey A. Leigler			ADDRESS Hyndman, Penna.		25a. REC'D BY REGISTRAR DATE MAY 31 '62
					25b. REGISTRAR'S SIGNATURE Arthur S. Harris

2222

CERTIFICATE OF DEATH

05004

ALLGANY

MARYLAND

ALLEGANY

CONSERVATION

6 DAYS

CORRIGANVILLE

MEMORIAL HOSPITAL

ADA

E. BRADIAN

MAY

FEMALE WHITE

1-17-1959

HOUSTON

SEWISYLVANIA

U.S.A.

LEWIS MERRY

MARGARET LAFERTY

MEMORIAL HOSPITAL - CONSERVATION, MARYLAND

DR. WILLIAM R. WOLKSTON

100 HARTSON STREET, CONSERVATION, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05259 CERTIFICATE OF DEATH 05255

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 17 DAYS		d. STREET ADDRESS 209 SOUTH ST.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVE. MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HANNAH M. BRADLEY		4. DATE OF DEATH MAY 28, 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-1873
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN HAWKINS		14. MOTHER'S MAIDEN NAME NANCY JENKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Hypertensive arterio-sclerotic Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-11-1962 to 5-28-1962 , that (I) (we) last saw the deceased alive on 5-28-1962 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. F. Williams M.D.		22b. DATE SIGNED 5/29/62	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1962	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 4 '62	
25b. REGISTRAR'S SIGNATURE Carlton S. Haines			

103216

103216

(M)

ALBERTA
HARVARD
CUMBERLAND
509 SOUTH ST.
MAY 20
BROOKLYN
1-25-1873
TWOBYBURD, MO.
NANCY JACKSON
JOHN PARKINS
WHITE
FEMALE
17 DAYS
GENERAL & PARKER AVE.
GENERAL HOSPITAL

*Important - please
check - check*

11:30 A.M.
DR. P. F. WILLIAMS
122 S. CENTER ST., CLY. EDWARD, IL.
JAMES E. ROBERTSON, CLY. EDWARD, IL.
JAMES E. ROBERTSON, CLY. EDWARD, IL.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05256

1. PLACE OF DEATH e. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cresaptown, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D. O. A. Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Curtis</u> Middle <u>Warren</u> Last <u>Breedlove</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1920</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Serviceman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking Company</u>		11. BIRTHPLACE (State or foreign country) <u>Thomas, West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Glenn W. Breedlove</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Douglas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>214-16-2160</u>		17. INFORMANT <u>Curtis C. Haines, Potomac Park, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 18, 1962</u>			
				Address (Street, city, town, or county) <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg, Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Frostburg, Maryland</u>	
23. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAY 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

05380

05380

05380



Handwritten signature

WILLIAM H. HARRIS

John A. Lee, Richmond, Maryland

1 FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>1 355 Baltimore Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Martin</u> Last <u>Broadwater</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 17, 1877</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supt (Maintenance) For a Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Broadwater</u>				14. MOTHER'S MAIDEN NAME <u>Susan Harmon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-1072</u>		17. INFORMANT <u>Mrs. Margaret Broadwater</u>		Address <u>355 Baltimore Ave, Cumberland Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Myocarditis</u> (c) <u>Arterio Sclerotic Cardio Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Hip</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Fell in garden</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:30</u> a.m. <u>May 12, 19 62</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home 221 Balt Ave</u>		20f. (City or town) (County) (State) <u>Cumberland Allegany Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>R.D.9 Cumberland Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR <u>H. Lee Silcox</u> <u>Cumberland Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 28 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Wm L. Hume</u>	

MEDICAL CERTIFICATION

DATE SIGNED
May 22, 1962

555-11

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

05262

CERTIFICATE OF DEATH

05258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Md.				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Minors Hosp., Frostburg, Md.				d. STREET ADDRESS Rural Frostburg			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN RAYMOND BROADWATER				4. DATE OF DEATH Month Day Year May 20 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1, 1885	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Cresaptown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Steven Broadwater				14. MOTHER'S MAIDEN NAME Charlotte Winters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT			
				Address Mrs. Laura Broadwater, RFD, Lonaconing			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Malaria DUE TO (b) Chn. Glomerulo Nephritis DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 12 d. ± 20 yrs. ± 20 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic C-v. disease and Hypertension							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to 5/20 , 19 62 , that I last saw the deceased alive on 5/20 , 19 62 , and that death occurred at 2:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Harrat M.D.				ADDRESS (Street, city or town, state) 26 W. Mechanic St Frostburg Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) FRANK T. HARRAT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/62		22c. NAME OF CEMETERY OR CREMATORY New Germany Methodist		22d. LOCATION (City, town, or county) (State) Grantsville, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman				ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR MAY 25 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kiper			

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *12/15/1910*

5. Date of death: *10/10/1955*

6. Place of death: *Home*

7. Cause of death: *Heart disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *10/15/1955*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05263

CERTIFICATE OF DEATH

05259

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS 232 CECILIA ST.	
3. NAME OF DECEASED (Type or print) CHARLES P. BUJAC JR.		4. DATE OF DEATH MAY 15 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1895
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Supvr.		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (County & State, or foreign country) Catonsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES D. BUJAC SR.		14. MOTHER'S MAIDEN NAME MARGARET FIZZEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 1		16. SOCIAL SECURITY NO. 705-03-6345	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Art. L. C. C. C. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State) Cumberland Allegany	
21. I certify that (I) (this hospital) attended the deceased from 5/15/62 7:18 P.M. to 5/15/62 2 , 19 62 , that (I) (we) last saw the deceased alive on 5/15/62 , 19 62 , and that death occurred at 5/15/62 , from the causes and on the date stated above.			
22a. SIGNATURE DR. RICHARD J. WILLIAMS		22b. DATE SIGNED 5/17/62	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/62	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR MAY 21 '62	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

452

1990

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
05264

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05260

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 35 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 407 MARYLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle M. Last BYRNE		4. DATE OF DEATH Month MAY Day 31 Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1906
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETAIL STORE	
11. BIRTHPLACE (State or foreign country) MISLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL A. BYRNE		14. MOTHER'S MAIDEN NAME ROSE ANN NOLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 05 7669	
17. INFORMANT MICHAEL J. BYRNE		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO hypertensive C.V. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with arteriosclerosis & atherosclerosis DUE TO fat embolism (c) fat embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) months		INTERVAL BETWEEN ONSET AND DEATH months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 31 19 60 to May 31 19 62 that (I) (we) last saw the deceased alive on May 31 19 62 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE B. M. Schindler		22b. DATE SIGNED June 3, 1962	
22c. PHYSICIAN'S NAME (Type) B. M. Schindler		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 4, 1962	
23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY		23d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR SEN 8 62 DATE	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Chas E. Hines	

08380

CERTIFICATE OF DEATH

2002

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05265

05261

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b Cumberland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 304 Maryland Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 304 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Geoffary Middle Arthur Last Caldwell		4. DATE OF DEATH Month May Day 12 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1892
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Mln. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Fire Co.	
11. BIRTHPLACE (County & State, or foreign country) Pratt Md. near Flintstone, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Matthew Caldwell		14. MOTHER'S MAIDEN NAME Josephine Browning	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8516	
17. INFORMANT Mrs. Geoffary Caldwell		Address 304 Maryland Ave. City	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis & Sepsis 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchiectasis DUE TO (c) 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 min INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1, 1962 to May 12, 1962 , that (I) (we) last saw the deceased alive on May 11, 1962 , and that death occurred at 11:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett M.D.		22b. DATE SIGNED 5/15/62	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett		22d. ADDRESS 236 Virginia Ave. Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/62	
23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City, town or county) (State) Hyndman, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25. REC'D BY REGISTRAR MAY 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

(M)

15868

Alimony

Married

301 Maryland Avenue

Geology

White

Exotic

Marine Biology

High School

Geology

301-2-8216 Mr. George Caldwell, 301 Maryland Ave. W.

Handwritten notes:
My mother is a geologist.
Geology

100 Gray St. Forest

100 Virginia Ave. Cambridge

John J. Water, Cambridge, Maryland

German Dictionary

German Dictionary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05262									
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Midland			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Midland			d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas F. Clise					4. DATE OF DEATH Month May Day 19 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1889		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Midland, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Clise					14. MOTHER'S MAIDEN NAME Mary Edwards				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Charles Clise Address Lonaconing, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV disease and DUE TO (c) hypertension					INTERVAL BETWEEN ONSET AND DEATH few minutes years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 5, 1962 to May 19, 1962 , that (I) (we) last saw the deceased alive on 5.14.1962 , and that death occurred at P.M. from the causes and on the date stated above.									
22a. SIGNATURE L.R. Miles, Jr., MD M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5.21.62		
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., MD					22d. ADDRESS LONACONING, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/62		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town or county) (State) Westernport, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn Address Lonaconing, Md.					25a. REC'D BY REGISTRAR DATE MAY 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House		

(M)

02388

02388

Allegany

Maryland

Allegany

Maryland

Maryland

Thomas, P.

Clise

May 19

SS

Male

White

X

March 11, 1889

Maryland, Maryland

U.S.A.

Resided

Charles Clise

Katy Edwards

Charles Clise

Residence, Md.

"son"

Burial 5/28/82

White Cemetery

Westonwood

George Richmond

Longmont, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05267					05263						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Allegany MARYLAND					a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing						
c. LENGTH OF STAY in 1b 3/9/1960					d. STREET ADDRESS Detmold Street						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			Elizabeth				Cooper		May 12, 1962		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/1888		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Crichton				14. MOTHER'S MAIDEN NAME Ora Anward				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT P.O. Box 599 Address Cumberland, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Venous thrombosis - 422.1 DUE TO (b) Diabetes Mellitus - DUE TO (c) Arterio Sclerosis & Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/9/1960 to 5/12/62 , that (I) (we) last saw the deceased alive on 5/11/62 , and that death occurred at 2:00 AM , from the causes and on the date stated above.										22b. DATE SIGNED 5/12/1962	
22a. SIGNATURE Lee B. Mathews				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS 49 Greene St., Cumberland, Md.			
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews											
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 5/14/1962		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) Lonaconing, MD.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS LONA CONING, MD.				25a. REC'D BY REGISTRAR MAY 14 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume					

1937

Allegany

Camdenland

Allegany County Jail

Allegation

Female White

Housewife

John Davidson

Connorsburg

Second Street

Cooper

3/12/1937

Connorsburg, Maryland

Dr. Amers

P.O. Box 509

Allegany County Jail

3/12/37

Dr. Lee P. Matthews

Allegation

Connorsburg, Maryland

3/12/37

3/12/1937

Dr. Greene St., Camdenland, Md.

Connorsburg, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN It 50yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) II Pennsylvania Ave.		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS II Pennsylvania Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Edward Davy		4. DATE OF DEATH May 25, 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1905
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tire Builder		10b. KIND OF BUSINESS OR INDUSTRY Auto Tire Plant	
11. BIRTHPLACE (County & State, or foreign country) Rig W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Davy		14. MOTHER'S MAIDEN NAME Daisy E. Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-8026	
17. INFORMANT Vernie F. Davy II		Address Pa. Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Artery Disease (c) 10 yrs -		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/6/55 to 5/25/62 19....., that (I) (we) last saw the deceased alive on 5/21/62 19....., and that death occurred at 11 AM , from the causes and on the date stated above.			
21a. SIGNATURE Richard J. Williams M.D.		21b. DATE SIGNED	
22. PHYSICIAN'S NAME (Type) Richard J. Williams		22a. ADDRESS Cumberland, Md 122 S. Centre	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-28-62	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24b. ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR MAY 31 '62		25b. REGISTRAR'S SIGNATURE James F. Scarpelli	

48329

CERTIFICATE OF DEATH

1933



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05269 CERTIFICATE OF DEATH 05265

1. PLACE OF DEATH a. COUNTY CUMBERLAND ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY (U. S.) Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUKE, MD.	
c. LENGTH OF STAY IN 1b 9 days		d. STREET ADDRESS 409 BROAD ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPHINE A. DIAZ		4. DATE OF DEATH MAY 30 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 24, 1888	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) SPAIN		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME (DECEASED) Ramon Alvarez		14. MOTHER'S MAIDEN NAME (DECEASED) Casimira Leon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT CHART		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic hepatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post operative transduodenal sphincterotomy DUE TO (c) Recurrent pancreatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland, Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 22, 1962, to May 30, 1962, that (I) (we) last saw the deceased alive on May 30, 1962, and that death occurred at 9:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Paul		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. PAUL		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/62	
23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City, town or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE El. B. B. B.		25a. REC'D BY REGISTRAR JUN 4 '62	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

03202

RECEIVED OF DEATH

03202

(M)

(I)

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten signature or name.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
Dr. Simons 05270

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05266

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown		c. LENGTH OF STAY IN 1b X Cresaptown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winchester Road		d. STREET ADDRESS Winchester Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Lee Last Frankhouser		4. DATE OF DEATH Month May 12, Day 12 , Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1883
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boiler Maker Power Co.		10b. KIND OF BUSINESS OR INDUSTRY Retired Boiler Maker Power Co.	
11. BIRTHPLACE (State or foreign country) Preston Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ami Frankhouser		14. MOTHER'S MAIDEN NAME Ellen Rodeheaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 233-16-7953	
17. INFORMANT Mrs. Grace Frankhouser		Address Cresaptown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578X Intestinal hemorrhage DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1960 to May 12, 1962 , that (I) (we) last saw the deceased alive on May 11, 1962 , and that death occurred at 11:12 M, from the causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED MAY 14, 1962	
22c. PHYSICIAN'S NAME (Type) George M. Simons		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15, 1962	
23c. NAME OF CEMETERY OR CREMATORY Friendsville Cem.		23d. LOCATION (City, town, or county) (State) Friendsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR DATE MAY 16 '62	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

03580

CERTIFICATE OF DEATH

2070

(M)

(1)

Handwritten signature and text, likely a name and date, appearing in the lower left section of the document.

Vertical stamp or text, possibly reading "CHIEF" or similar, located in the lower center of the page.

Large handwritten signature or name, possibly "George", located in the lower right section of the document.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

05271
M
X
1
M
0
2
M
2
VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
05267

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 38 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland			d. STREET ADDRESS 322 Bedford Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 322 Bedford Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ralph Middle W Last Frantz					4. DATE OF DEATH Month May Day 6 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1885		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto		10b. KIND OF BUSINESS OR INDUSTRY Mechanic		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William F. Frantz					14. MOTHER'S MAIDEN NAME Dide Elizabeth Wickard				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 220-10-7592		17. INFORMANT Ralph F. Frantz		Address 322 Bedford Street, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) ?									INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 6, 62 Address (Street, city, town, or county) R.D.9 Cumberland, Md									
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/62		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland Maryland		(State)	
23. FUNERAL DIRECTOR ADDRESS Ruth E. Silcox Cumberland Maryland					24a. REC'D BY REGISTRAR MAY 8 '62		24b. REGISTRAR'S SIGNATURE Charles L. House		

05583

17337

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1

ALLEGANY

CUMBERLAND

CLARA

WHITE

FEMALE

X

1-10-09

FULLER

WAY

30

65

MARYLAND

CUMBERLAND

ALLEGANY

313 PENNSYLVANIA AVENUE

MEMORIAL HOSPITAL - MEMORIAL AVE.

RHODA RAVENSCROFT

RICHARD ROBINSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MD.

Children of Clara

DR. C. C. GORTON, PHILADELPHIA

133 VIRGINIA AVE., CUMBERLAND, MD.

Open in May 1909

John J. Gorton

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05273

05268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>MOUNT SAVAGE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SYLVAN RETREAT</u>		d. STREET ADDRESS <u>1 COLUMBIA AVENUE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY GAUGHAN</u>		4. DATE OF DEATH Month Day Year <u>MAY 3 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MOUNT SAVAGE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW GAUGHAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. BRIDGET GAUGHAN</u>		Address <u>MT. SAVAGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CARDIAC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CHRONIC MYOCARDITIS</u> (c) <u>CORONARY SCLEROSIS; AORTIC AND MITRAL STENOSIS</u> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>May 3, 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 5, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. SAVAGE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Leigler, Hyndman, PA</u>		24a. REC'D BY REGISTRAR <u>MAY 7 '62</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thayer</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) West Main Street						d. STREET ADDRESS West Main Street					
3. NAME OF DECEASED (Type or print) First Homer Middle Jacob Last Gentry						4. DATE OF DEATH Month May Day 27 Year 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 24, 1905		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Franklin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Charles Gentry						14. MOTHER'S MAIDEN NAME Stella Turner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. 215-10-8082					
17. INFORMANT Address Westernport, Md.						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound Left occipital 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Area Laceration of Brain DUE TO (c) Hemorrhage Sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with shotgun.					
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. May 27, 1962						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home						20f. City or town (County) (State) Lonaconing Allegany Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W O McLane						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) W O McLane MD						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 5/30/62					
22c. NAME OF CEMETERY OR CREMATORY Senset Memorial Park						22d. LOCATION (City, town, or country) (State) Cumberland, Maryland					
23. FUNERAL DIRECTOR George Eichhorn						24a. REC'D BY REGISTRAR Arthur S. Thoma					
ADDRESS Lonaconing, Md.						DATE JUN 1 '62					

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(M)

(1)

Estimated amount of property value
of the estate of the deceased
the mortgage

that will result in the
the mortgage

the mortgage

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in lb 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING d. STREET ADDRESS 3 ADVOCATE COURT a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VERNA First Middle Last GETTY First Middle Last female SEX WHITE COLOR OR RACE WIDOWED MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> HOUSEWIFE USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARYLAND BIRTHPLACE (County & State, or foreign country) U.S.A. CITIZEN OF WHAT COUNTRY?		4. DATE OF DEATH Month Day Year MAY 20 1962 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME James Schuler		14. MOTHER'S MAIDEN NAME Catherine McIndoe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Gorman Getty		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Acute myocardial infarction with circulatory collapse DUE TO (c) Arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH 30 hours 38 hours 8 months (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 18th, 1962, to May 20th, 1962 that (I) (we) last saw the deceased alive on May 19th, 1962, and that death occurred at 7:37 PM, from the causes and on the date stated above.			
22a. SIGNATURE Wyand F. Doerner, Jr., M.D. M.D. 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED MAY 21, 1962 22d. ADDRESS 414 N. Mechanic Street, Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/62	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR MAY 24 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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Escherichia Coli

James G. G. G.

University of

Georgia Tech

none

no

University of

Georgia Tech

University of

May 1964

7:31

7:31

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Georgia Tech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05276
05271

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b CUMBERLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 345 BALTIMORE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN WILLIAM HARCLERODE		4. DATE OF DEATH Month 5 Day 5 Year 19 62		5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-7-1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Conductor		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (County & State, or foreign country) Manns Choice Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hezekiah Harclerode		14. MOTHER'S MAIDEN NAME Anna Suter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-5629		17. INFORMANT CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Left Lung (Inoperable) DUE TO (b) Myocarditis & Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 1, 1962 to May 5, 1962 that (I) (we) last saw the deceased alive on May 4, 1962 and that death occurred at 3:30 am from the causes and on the date stated above.		22a. SIGNATURE Clayton L. Durrett		22b. DATE SIGNED 5/6/62		22c. PHYSICIAN'S NAME (Type) DR. DURRETT		22d. ADDRESS 303 GRANDE AVE.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/1962		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City, town or county) (State) Hyndman, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		25a. REC'D BY REGISTRAR MAY 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House		25c. ADDRESS Cumberland, Maryland		25d. DATE		25e. TIME		25f. PLACE		25g. STATE		25h. COUNTY	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05277

CERTIFICATE OF DEATH

05272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp.		d. STREET ADDRESS 121 Potomac St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Bessie Last Hartman		4. DATE OF DEATH Month May Day 6 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1886
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria Employee		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Hartman		14. MOTHER'S MAIDEN NAME Margaret Ann Pendergast	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 217-10-4125	
17. INFORMANT Mrs. Richard H. Turner		Address Cumb. Md. 121 Potomac St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) Sinus INTERVAL BETWEEN ONSET AND DEATH 1958			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12.5. 1955 to 5.6. 1962 that I last saw the deceased alive on 4.9. 1962 and that death occurred at 3:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED 5/8/62 ACTUAL SIGNATURE W. F. Williams M.D. PHYSICIAN'S NAME (Type) W. F. Williams M. D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/62	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE MAY 11 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

05375

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

05375

DATE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05278 CERTIFICATE OF DEATH 05273

1. PLACE OF DEATH e. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Flintstone, Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Flintstone, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pleasant Valley Road		d. STREET ADDRESS Pleasant Valley Road	
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Hauser		4. DATE OF DEATH Month May Day 23 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Hauser		14. MOTHER'S MAIDEN NAME Katherina Troll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 220-3800357	
17. INFORMANT Mrs. Ambrose Miltenberger, Flintstone		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 61 , to 5/23 , 19 62 , that (I) (we) last saw the deceased alive on 3/14 , 19 62 , and that death occurred at 6 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Ley Jr. M.D.		22b. DATE SIGNED 5/23/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR.		22d. ADDRESS 452 N. Centre St. Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 25, 1962	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAY 31 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



052578

052578

UNITED STATES OF AMERICA

James H. Brown

James H. Brown
120 H 1st St
Waco, Texas

Waco, Texas
James H. Brown
120 H 1st St

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05279 CERTIFICATE OF DEATH 05274

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 1 30 VICTORIA LANE	
3. NAME OF DECEASED (Type or print) First MARY Middle V. Last HOLTZ		4. DATE OF DEATH Month MAY Day 6TH Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26TH, 1880
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSEWORK	
11. BIRTHPLACE (County & State, or foreign country) ROUMANIA		12. CITIZEN OF WHAT COUNTRY? ROUMANIA	
13. FATHER'S NAME THEODORE VIRCA		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. JOSEPH DORMIO, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular disease (c) 10 days INTERVAL BETWEEN ONSET AND DEATH 10 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from April 1962 to May 1962 that (I) (we) last saw the deceased alive on May 1962, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-9-62	
23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY		23d. LOCATION (City, town or county) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durnst		25a. REC'D BY REGISTRAR MAY 11 1962	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE	

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Handwritten notes:
The above is a copy of the original
document. It is not a reproduction of the original.

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The above is a copy of the original
document. It is not a reproduction of the original.

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The above is a copy of the original
document. It is not a reproduction of the original.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05280 CERTIFICATE OF DEATH 05275

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gilmore, R&F-D. #1 Frostburg d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First William Middle C. Last Hoops		4. DATE OF DEATH Month 5 Day 17th Year 1962 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1888
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Aberdeen, MD.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hoops		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes-World War 1&2		16. SOCIAL SECURITY NO. 216-01-0161	
17. INFORMANT Mrs. William Hoops, Gilmore, MD		Address (WIFE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 443X DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic Hypertensive disease Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary Emphysema + Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 min ± 10 yrs ± 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9 to May 17, 1962 , that (I) (we) last saw the deceased alive on May 17, 1962 , and that death occurred at 1:41 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frank T. Hararat		22b. DATE 5/18/62	
22c. PHYSICIAN'S NAME (Type) FRANK T. HARARAT		22d. ADDRESS 26 W. Meekanic St. Frostburg	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/1962	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		25a. REC'D BY REGISTRAR DATE MAY 23 '62	
ADDRESS LONACONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
15M 7/61

10282

10280

M

3

Allegany Maryland
Clinton, Md. 11th District

William O. Hoops
Male White
Retired
Born 1888
U.S.A.

William Hoops
Yes World War I
Mrs. William Hoops, Clinton, Md.
(Wife)

George Richmond
Frank Richmond
June 11, 1911
Frank Richmond
George Richmond

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McCoole						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Home) R.F.D.3 Keyser, W.Va.						d. STREET ADDRESS R.F.D.3 Keyser, W.Va.					
3. NAME OF DECEASED (Type or print) Frank Iacovone						4. DATE OF DEATH May. 19, 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March. 3, 1891		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 2 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trackman				10b. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 705-12-4656		17. INFORMANT Frank Iacovone, Keyser, W.Va. (Son)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO (c) -----											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 5-22-62		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or country) (State) Keyser, W.Va.	
23. FUNERAL DIRECTOR Thomas Smith Jr.						24a. REC'D BY REGISTRAR MAY 21 '62		24b. REGISTRAR'S SIGNATURE William S. Kraw			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 19, 1962			
ACTUAL SIGNATURE Benedict Skitarelic						M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			

00330

00330

(M)

UNKNOWN

UNKNOWN

CONVICT DOUGLAS

CONVICT STEWART

James M. Smith

May 19, 1901

Cambridge, Md.

W. Thomas Combs, Mayor, Va.

James M. Smith, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05282 CERTIFICATE OF DEATH 05277

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIDGELEY, W. VA c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. VA. b. COUNTY MINERAL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIDGELEY, W. VA d. STREET ADDRESS 20 WABASH ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) GEORGE EDWARD JUSTICE			4. DATE OF DEATH Month MAY Day 20 Year 19 62		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1916	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainman		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.		11. BIRTHPLACE (County & State, or foreign country) HENDRICKS, W. VA	
13. FATHER'S NAME ALONZO JUSTICE			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.			16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia - severe 443X DUE TO (b) Hypertensive cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) disease - severe			INTERVAL BETWEEN ONSET AND DEATH 5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5/14 62	(County) 5/20 62 (State)
21. I certify that (I) (this hospital) attended the deceased from 5/14 62 to 5/20 62 , that (I) (we) last saw the deceased alive on 5/20 62 and that death occurred at 7:50 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Thomas J. Lusby M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/21/62
22c. PHYSICIAN'S NAME (Type) DR. THOMAS LUSBY			22d. ADDRESS 125 BEDFORD ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/62	23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City, town or county) Fort Ashby, W. Va. (State)
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.			25a. REC'D BY REGISTRAR MAY 24 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kline

10533

10533

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

05283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05278

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/18/59	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Frederick Kerber		4. DATE OF DEATH Month May Day 24 , Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Merchant		9. AGE (In years last birthday) 85 yrs. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY Shoe Store		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland	
13. FATHER'S NAME John Kerber		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. MOTHER'S MAIDEN NAME Josephine Berkhard		17. INFORMANT P.O. Box 599, Address Cumberland, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-4354A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus pneumonia 422.1 DUE TO Myocarditis, chronic degeneration Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO General Arteriosclerosis, Senile PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/18/59 19....., to 5/24/62 19....., that (I) (we) last saw the deceased alive on 5/24/62 19....., and that death occurred at 6:30 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 5/25/62	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/62	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAY 28 '62	
		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

(M)

05223

05223

Allegany

Allegany

Allegany

Cumberland

3/18/52

3/18/52

Allegany County Jail

52 Term Prison

William

Frederick

Robert

May

24

White

M

12/22/1946

82

Religion: Catholic

Occupation

Cumberland, Maryland

J. D. A.

John Robert

Associate Engineer

Cumberland, Md.

521-05-13514 Allegany County Jail

Handwritten notes:
John Robert
White
Catholic
Cumberland, Md.

2/25/52

2/25/52

2/25/52

Dr. Joe B. Nichols

Dr. Greene St., Cumberland, Md.

2/25/52

2/25/52

2/25/52

Charles E. George

Cumberland, Md.

Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05284

05279

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY in 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		e. RT. 5, CUMBERLAND, MD. d. STREET ADDRESS BOX 385	
3. NAME OF DECEASED (Type or print) First FRANK Middle HENRY Last KLOSTERMAN		4. DATE OF DEATH Month MAY Day 12TH Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 28TH, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. LABORER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINING	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN H. KLOSTERMAN		14. MOTHER'S MAIDEN NAME SARAH K. COOK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 217-10-1893	
17. INFORMANT FRANCIS L. KLOSTERMAN, MT. SAVAGE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 422.2 DUE TO (b) Arterio sclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 12, 1962 to May 12, 1962 , that (I) (we) last saw the deceased alive on May 12, 1962 and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Womc Lane M.D.		22b. DATE SIGNED May 12 1962	
22c. PHYSICIAN'S NAME (Type) Womc Lane M.D.		22d. ADDRESS Frostburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-14-62	23c. NAME OF CEMETERY OR CREMATORY REST LAWN CEMETERY	23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		25a. REC'D BY REGISTRAR DATE MAY 16 '62	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05285 CERTIFICATE OF DEATH 05280											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. LENGTH OF STAY IN b 3 Weeks					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LAVALE					
d. STREET ADDRESS 99 NATIONAL HIGHWAY						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last BROSIA MAY LASHLEY						4. DATE OF DEATH Month Day Year MAY 20 19 62					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-1879		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME SAMUEL RICE (D)						14. MOTHER'S MAIDEN NAME ELLEN(D) Valentine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT PT'S CHART Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) uremia - azotemia 450.0 DUE TO (b) arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, Intertrochanteric Left Hip											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from April 30 19 62 to May 20 19 62 that (I) (we) last saw the deceased alive on May 20 19 62 , and that death occurred at 3:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Richard E. Schindler M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 21-62			
22c. PHYSICIAN'S NAME (Type) DR. R. SCHINDLER						22d. ADDRESS 69 GREENE STREET CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/62		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park				23d. LOCATION (City, town or county) (State) Cumberland Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland Maryland						25a. REC'D BY REGISTRAR MAY 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House			

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00282

CENTRAL BANK OF DENVER

00281

Antoniou, George
Denver - Colorado

Structure, Antoniou, George

Antoniou, George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film G314 6/14/62 iwr

05286

05281

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 OAKLAND Cumberland d. STREET ADDRESS 'Cuppeth' Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First REBECCA Middle P. Last LAYMAN				4. DATE OF DEATH Month MAY Day 14 Year 19 62							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 20, 1881		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES ATHEY				14. MOTHER'S MAIDEN NAME MOLLIE HENDRICKSON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service) —			
16. SOCIAL SECURITY NO. none				17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND Address INTERVAL BETWEEN ONSET AND DEATH				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Squamous Cell Carcinoma of Cervix			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.											
22a. SIGNATURE Louis Steen Inc. M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. L. LOUIS MOULD				22d. ADDRESS 1068 NATIONAL HIGH WAY, LA VALE, MARYLAND							
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 5/17/62		23c. NAME OF CEMETERY OR CREMATORY Greenmount Can		23d. LOCATION (City, town or county) (State) Cumberland Md					
24. FUNERAL DIRECTOR'S SIGNATURE Louis Steen Inc. Cumberland Md ADDRESS				25a. REC'D BY REGISTRAR MAY 21 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. France					

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103501

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Charles Henry

AUGUST 20, 1961

WHITE

WYLAND

CHARLES ARLEY

MOLLE HENDRICKSON

Black Female

Admission to Hospital

Admission to Hospital

Admission to Hospital

100 NATIONAL HIGHWAY, WYLAND

DR. E. LOUIS KUCLO

Admission to Hospital
Admission to Hospital
Admission to Hospital

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05282

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Rt. # 5 Cumberland,			
c. LENGTH OF STAY in 1b				d. STREET ADDRESS Triple Lakes,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D. O. A. Sacred Heart Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle CHARLES Last LEASE JR.				4. DATE OF DEATH Month May Day 18, Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1929		9. AGE (in years last birthday) 32 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Triple Lakes, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer C. Lease				14. MOTHER'S MAIDEN NAME Bessie Hart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No,		16. SOCIAL SECURITY NO. 212-24-2417		17. INFORMANT Mrs. Geraldine Lease Rt. # 5 Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) TRAUMATIC COMPRESSION OF CHEST DUE TO (c) 10 Min.						INTERVAL BETWEEN ONSET AND DEATH 5-8 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Pinned in cab of run-away truck					
20c. TIME OF INJURY Month, Day, Year Apple 2:30 p.m. May 18, 1962		20d. INJURY OCCURRED While/ Not While at work <input checked="" type="checkbox"/> al work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) W. Va. State Hwy. City, Mineral W. Va.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarellic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED May 18, 1962			
				Address (Street, city, town, or county) Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/62		22c. NAME OF CEMETERY OR CREMATORY Lease Cemetery		22d. LOCATION (City, town, or county) (State) Cresaptown, Maryland	
23. FUNERAL DIRECTOR Charles L. George Cumberland, Md.				24a. REC'D BY REGISTRAR MAY 21 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

58283

58283



Handwritten signature

Charles L. George, President

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05288 CERTIFICATE OF DEATH 05283													
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL - CUMBERLAND, MD.						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS RT. #5 TRIPLE LAKES e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) RICHARD WILLIAM LEASE						4. DATE OF DEATH MAY 22, 1962							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 14, 1899		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10b. KIND OF BUSINESS OR INDUSTRY American Bridge				11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Allegany		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM LEASE						14. MOTHER'S MAIDEN NAME MARGARET MC KENZIE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. 349-05-9097						17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Atherosclerosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cardiac decompensation sec to 1-2 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 5/22/62 , 19 62 to 5/22/62 , 19 62 that (I) (we) last saw the deceased alive on 5/22/62 and that death occurred at 4:00 A.M. the causes and on the date stated above.													
22a. SIGNATURE George M. Simons M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/25/62					
22c. PHYSICIAN'S NAME (Type) DR. GEORGE S. SIMONS						22d. ADDRESS ALCONQUIN HOTEL., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/62		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.						ADDRESS		25a. REC'D BY REGISTRAR MAY 28 '62		25b. REGISTRAR'S SIGNATURE Wm. L. Thomas			

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ALLEGANY

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CUMBERLAND

3 DAYS

CUMBERLAND

RT. 25 TRIPLE LAKE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

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RICHARD

XX SEPTEMBER 14, 1959 CS

WHITE

U.S.A.

A. TRICKS, JR., JURYMAN, ALLEGANY

80000 WORKER

MARGARET MC KENZIE

WILLIAM LEAS

MEMORIAL HOSPITAL - CUMBERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05289

CERTIFICATE OF DEATH

05284

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 16 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL - CUMBERLAND, MD.				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 1823 BEDFORD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) KATIE L. LIBLE		4. DATE OF DEATH Month MAY Day 22 Year 19 62		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 5, 1890		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES E. TRIBER				14. MOTHER'S MAIDEN NAME MARY E. ALBRIGHT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and burnin, Intestinal Obstruction 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma Cecum to DUE TO (c) Colon												INTERVAL BETWEEN ONSET AND DEATH 11 days 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 19 57 to May 22 19 62 that (I) (we) last saw the deceased alive on May 22 19 62 and that death occurred at 2:10 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE Carlton Brinsfield M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD				22d. ADDRESS 401 DECATUR STREET, CUMBERLAND, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/24/62				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town or county) Cumberland Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland				25a. REC'D BY REGISTRAR DATE MAY 28 '62				25b. REGISTRAR'S SIGNATURE Arthur L. Hanks							

(M)

LEGACY

LEGACY

LEGACY

CUMBERLAND

10 DAYS

CUMBERLAND

MEMORIAL HOSPITAL - CUMBERLAND, MD. 1025 BEYOND STREET

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JANUARY 2, 1902 TO

WHITE

CUMBERLAND, MARYLAND, U.S.A.

CHARLES E. THIBER

MARY E. ALBRIGHT

MEMORIAL HOSPITAL, CUMBERLAND, MD.

*Shirley and family, better condition
than when we saw them
last*

DR. CARLTON BRINGFIELD

401 DECATUR STREET, CUMBERLAND, MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05290

05285

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 26 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG		d. STREET ADDRESS 1 4 CHESTNUT ST	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JEAN M. LOWRY				4. DATE OF DEATH Month MAY Day 16 , Year 19 62			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 29, 1881	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES MASON				14. MOTHER'S MAIDEN NAME JENNIE BAILEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address JAMES LOWRY, 4 CHESTNUT ST. FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture Rt Humerus (a), stating the underlying cause last. (c) Left Femur						INTERVAL BETWEEN ONSET AND DEATH 6 hrs 2 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in her home					
20c. TIME OF INJURY Hour 10:00 a.m. May 14 19 62 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Her home		20f. (City or town) Frostburg (County) Allegany (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W O McLane EXAMINER'S NAME (Type) W. O. McLANE, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Frostburg MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 19, 1962		22c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		22d. LOCATION (City, town, or country) (State) FROSTBURG, MD.	
23. FUNERAL DIRECTOR R. J. Darnell		ADDRESS FROSTBURG, MD.		24a. REC'D BY REGISTRAR DATE MAY 22 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05291					05286						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Dawson</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>rural-Dawson</u>						
c. LENGTH OF STAY IN 1b <u>4 Yrs.</u>					d. STREET ADDRESS <u>1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<u>Anna</u>		<u>Marion</u>		<u>Lyons</u>		Month <u>May</u> Day <u>31</u> Year <u>1962</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Allegany-Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Sheetz</u>					14. MOTHER'S MAIDEN NAME <u>Amanda Dick</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gladys Dawson, R. J. Keyser, W. Va.</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) <u>Chronic Myocarditis and Myocardial Degeneration Not specified as Rheumatic</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u>19</u>		Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 10, 1959</u> to <u>May 31, 1962</u> that (I) (we) last saw the deceased alive on <u>May 16, 1962</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul R. Wilson</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 1, 1962</u>				
22c. PHYSICIAN'S NAME (Type) <u>Paul R. Wilson</u>					22d. ADDRESS <u>Piedmont, W. Va.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>				23d. LOCATION (City, town or county) (State) <u>Westernport Md.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Bual</u>					ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>		

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Don Williams

Bill Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05292 CERTIFICATE OF DEATH 05287

1. PLACE OF DEATH e. COUNTY Allegany f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Westernport g. LENGTH OF STAY IN 1b 5 Minutes h. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2 1/2 Mi. N. of Westernport		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport 43 d. STREET ADDRESS 207 Popular e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sadie Lyons First Middle Last		4. DATE OF DEATH May 10 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1883 9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Allegany-Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Warnick		14. MOTHER'S MAIDEN NAME Jeanie Keirs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Russell L. Broy-Westernport, Md. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 Years DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 10, 1957 to May 10, 1962 that (I) (we) last saw the deceased alive on April 5, 1962 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson 22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22b. DATE SIGNED May 11, 1962 22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/62	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town or county) (State) Moscow Mills Md.	
24. FUNERAL DIRECTOR'S SIGNATURE El. Boul ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR MAY 14 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hance	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05293					05288				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Allegany		Frostburg			Maryland		Allegany		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Fairview Street					Lonaconing		West Main Street		
e. IS RESIDENCE ON A FARM?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
Robert S. Marshall					May 2 19 62				
5. SEX					6. COLOR OR RACE				
Male					White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH				
					February 24, 1897				
9. AGE (In years last birthday)					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				
65 yrs.					Retired				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
W.Va Paper Mill Lonaconing, Maryland					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William Marshall					Rachel Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
yes					217-03-2168				
17. INFORMANT					Address				
Mrs. Robert Marshall					Lonaconing, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X					Immediate				
DUE TO (b) Diabetes mellitus, moderately severe.					??				
DUE TO (c) Arteriosclerotic cardiovascular disease, arterial					2-3 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY					20d. INJURY OCCURRED				
Hour e.m. p.m. 19					While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12 July 19 60 to 2 May 19 62, that (I) (we) last saw the deceased alive on 5 March 19 62, and that death occurred at 1:20 PM from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
W. Alfred Van Ormer					5/4/62				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
W. Alfred Van Ormer, M. D.					122 South Centre St., Cumberland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)	
Burial			5/5/62		Memorial Park			Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR				
George Eichhorn					MAY 7 1962				
ADDRESS					25b. REGISTRAR'S SIGNATURE				
Lonaconing, Md.					C. A. Smith				



Allegany

Frederick

Frederick Street

Roberts

White

married

William Marshall

yes

Barryland

Londoning

West Main Street

Marshall

February 24, 1897

U.S. Forest Hill Londoning, Maryland, U.S.A.

Recher Smith

Isaac K. Kar 217-03-2182 to Robert Marshall Londoning, Md.

White

Diabetes Mellitus, essentially chronic.

Arteriosclerosis of the heart and arteries.

2 March

W. Alfred Van Meter, M.D.

Baptist

5/5/03

Memorial Park

George Nicholson

Londoning, Md.

Frederick

Allegany

05283

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05294

05289

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 236 Paca Street			
3. NAME OF DECEASED (Type or print) Alexander Francis Mattingly				4. DATE OF DEATH May 14 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/28/1905	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmen Helper		9b. KIND OF BUSINESS OR INDUSTRY B&O Bolt & Forge		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. BIRTHPLACE (State or foreign country) Mt. Savage, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Alexander Mattingly				14. MOTHER'S MAIDEN NAME Veronica Murphy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-05-6715			
17. INFORMANT Mrs. Alexander Mattingly				Address 236 Paca Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular Disease (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----						INTERVAL BETWEEN ONSET AND DEATH 10 hrs.	
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 14, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/17/1962		22c. NAME OF CEMETERY OR CREMATORY St. Peter's & Paul's	
22d. LOCATION (City, town, or country) Cumberland, Maryland				22e. REC'D BY REGISTRAR May 18 '62			
23. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland				24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

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John J. Baker, Minister, Kingston

Wm. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

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Rev. J. J. Baker, Minister, Kingston

Rev. J. J. Baker, Minister, Kingston

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Rev. J. J. Baker, Minister, Kingston

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FOR STATE
HEALTH DEPT. **M**
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05290

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 50 YEARS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 417 FURNACE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 417 FURNACE STREET				4. DATE OF DEATH Month Day Year MAY 29 1962									
3. NAME OF DECEASED (Type or print) First Middle Last EMMA L. McCOY													
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 25, 1907		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JERMLAH LONG				14. MOTHER'S MAIDEN NAME EVELYN WILLS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ANDREW G. McCOY		Address CUMBERLAND, MARYLAND							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (e), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) WINCHESTER, VA.		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) R9 Cumberland, Md. DATE SIGNED May 29, 1962													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 1, 1962		22c. NAME OF CEMETERY OR CREMATORY MT. HEBRON CEMETERY		22d. LOCATION (City, town, or country) WINCHESTER, VA.							
23. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.				24a. REC'D BY REGISTRAR DATE JUN 1 '62				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

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Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

05296

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05291

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Midland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle M. Last MEYERS		4. DATE OF DEATH Month 5/6/1962 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1911
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 19 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Frostburg, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME James McGann	
14. MOTHER'S MAIDEN NAME Mary ann Durkin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John Meyers Address Midland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 mo DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma Left Breast		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2, 1961 to May 5, 1962 that (I) (we) last saw the deceased alive on May 2, 1962 and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE WOMc Lane M.D.		22b. DATE SIGNED May 7, 1962	
22c. PHYSICIAN'S NAME (Type) WOMc Lane MD		22d. ADDRESS Frostburg MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/1962	
23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR MAY 8 '62	
ADDRESS Lonaconing MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10831

CENTRAL OF ILLINOIS

10831



Albany

Albany

Albany

Albany

Albany

5/6/1902

10831

JOSEPHINE

20

2/27/1911

White

Female

U.S.A.

Proctor, W.

Minneapolis

Mary Ann

James P. Conn

Albany, N.Y.

Mr. John F. Conn
(Albany)

None

10

Albany, N.Y.

St. Michael's Cemetery

5/6/1902

10831

Albany, N.Y.

George Michon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05292

05292

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22 d. STREET ADDRESS 114 Maple Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR CECIL MICHAEL		4. DATE OF DEATH Month 5 Day 25th Year 19 62.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (County & State, or foreign country) Garrett County
13. FATHER'S NAME Nathan Thomas Michael		14. MOTHER'S MAIDEN NAME Frances Dawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 219-03-8586	
17. INFORMANT Mrs. Edgar Michael, 114 Maple St., Frostburg, Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Left Hemiplegia (a), stating the underlying cause last. (c) Arterio Sclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 Days INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 14, 1962, to May 25, 1962, that (I) (we) last saw the deceased alive on May 25, 1962, and that death occurred at 6:10 P.M., from the causes and on the date stated above.			
22a. SIGNATURE WOMC Lane M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED May 26/62
22c. PHYSICIAN'S NAME (Type) WOMC LANE MD		22d. ADDRESS Frostburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/62	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.
24. FUNERAL DIRECTOR'S SIGNATURE Bulah H. Montross		25a. REC'D BY REGISTRAR MAY 31 62	25b. REGISTRAR'S SIGNATURE Arthur S. Kline

80308

13307



Attest
Witnessed by
In presence of
The undersigned
County of
State of

Notary Public
My commission expires
I hereby certify that
the foregoing is a true and
correct copy of the
original as the same
was presented to me
for recording.

Witness my hand and seal
this 1st day of
January, 1908.
Notary Public
for the State of



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3-4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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05298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05293

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 19 1/2 GRAND AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH T. MILLER				4. DATE OF DEATH Month Day Year MAY 8 19 62			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1909	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Hauling		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH M. MILLER				14. MOTHER'S MAIDEN NAME ELLA PEARL ATHEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 214-05-9798		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Ventricular Fibr 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Coronary Artery Disease DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 yrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour e.m. p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland City Md		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/7/62 9:33 P.M. 19 62 that (I) last saw the deceased alive on 5/7/62 19 62 , and that death occurred at 5/8/62 M, from the causes and on the date stated above.							
22a. SIGNATURE DR. RICHARD J. WILLIAMS M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/9/62	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-62		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 14 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

00333

CERTIFICATE OF DEATH

00333

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123 GARD AVE

123 GARD AVE

NEW HAVEN HOSPITAL

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

05299 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05294

1. PLACE OF DEATH e. COUNTY Allegany f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing g. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) East Main Street				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS East Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William		First Moffatt		Middle Moffatt		Last Moffatt		4. DATE OF DEATH May 14 19 62	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 12, 1896		9. AGE (In years last birthday) 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY County Road Dept		11. BIRTHPLACE (State or foreign country) Pekin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Robert Moffatt				14. MOTHER'S MAIDEN NAME Martha Sourbrine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W.War 1		17. INFORMANT Mrs. William Moffatt Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) "Wife"				INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic				M.D. BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 14, 1962	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				Address (Street, city, town, or county) CUMBERLAND, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17th. 1962		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or country) (State) Lonaconing, Md.			
23. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR MAY 18 '62		24b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05300

05295

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN 1b <u>7 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u> d. STREET ADDRESS <u>254 COLUMBIA ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>VIRGIL</u> Middle <u>NICKEL</u> Last <u>NICKEL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>19 62</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 8, 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HENRY NICKEL</u>						14. MOTHER'S MAIDEN NAME <u>ARABELLE GULLERY</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>PATIENT'S CHART</u> Address <u> </u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Chronic Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ASHD</u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> <u>1961</u> , to <u>May 7, 1962</u> , that (I) (we) last saw the deceased alive on <u>May 6, 1962</u> , and that death occurred <u>10:15 A.M.</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>William P. James</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MD. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>421 N. Main St., Cumberland, Md.</u>				22b. DATE SIGNED <u>5/7/62</u>					
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/9/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis's Luth. Cem.</u>				23d. LOCATION (City, town or county) <u>Cumberland Md</u> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md.</u>						25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 10 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 708 Frederick St.,					d. STREET ADDRESS 708 Frederick St.,				
3. NAME OF DECEASED (Type or print) EDWARD COLUMBUS PAUGH					4. DATE OF DEATH Month May Day 5 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1902		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Plt. Opr,		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison		11. BIRTHPLACE (State or foreign country) Gormer, Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Paugh					14. MOTHER'S MAIDEN NAME Pearl Scott				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No,					16. SOCIAL SECURITY NO. 214-10-3927				
17. INFORMANT Mrs. Montra S. Paugh					Address Cumb. Md. 708 Frederick St.,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0									INTERVAL BETWEEN ONSET AND DEATH SUDDEN
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. # 9				
					Address (Street, city, town, or county) Cumberland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/62		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park, Cumberland, Maryland			22d. LOCATION (City, town, or country) (State)		
23. FUNERAL DIRECTOR H. Wayne George					ADDRESS Cumberland, Maryland				
24a. REC'D BY REGISTRAR MAY 9 '62					24b. REGISTRAR'S SIGNATURE Arthur L. Hanna				

May 5, 1962
DATE SIGNED



Handwritten signature

[Faint, mostly illegible text covering the page, possibly a form or document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05302 CERTIFICATE OF DEATH 05297

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b. 58 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give full address) MEMORIAL HOSPITAL AVE.		d. STREET ADDRESS ROUTE # 1 BOX 153		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PERRY		4. DATE OF DEATH MAY 9 1962		5. SEX MALE	
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-11-1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER-RETIRED	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOSEPH POLAND	
14. MOTHER'S MAIDEN NAME NANCY CLARKE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 213-09-6469		16. SOCIAL SECURITY NO. 213-09-6469	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal renal failure 442 X DUE TO Chronic pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic Cardio-vascular-Renal Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Hypertrophy prostatic with obstruction 4 months INTERVAL BETWEEN ONSET AND DEATH 3 months 3 + month ??		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 Feb. 1962 to 9 May 1962, that (I) (we) last saw the deceased alive on 8 May 1962, and that death occurred 5:45 AM, from the causes and on the date stated above.					
22a. SIGNATURE W. Alfred Von Ormer M.D.		22b. DATE SIGNED 9 May 62		22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER	
22d. ADDRESS 122 S. Gate St. Cumberland, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-11-62	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.		24. FUNERAL DIRECTOR'S SIGNATURE J. P. Burrost	
25a. REC'D BY REGISTRAR DATE MAY 14 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		25c. ADDRESS FROSTBURG, MD.	

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CERTIFICATE OF DEATH

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COUNTY OF CUMBERLAND CITY OF BALTIMORE DEPARTMENT OF HEALTH		COUNTY OF MARYLAND CITY OF BALTIMORE DEPARTMENT OF HEALTH	
NAME: JOSEPH POLAND RACE: WHITE SEX: MALE DATE OF BIRTH: 11-11-1886 PLACE OF BIRTH: MARYLAND		NAME: FRANK FROST RACE: WHITE SEX: MALE DATE OF BIRTH: 11-11-1886 PLACE OF BIRTH: MARYLAND	
DECEASED AT: BALTIMORE, MARYLAND PLACE OF DEATH: BALTIMORE, MARYLAND DATE OF DEATH: 11-11-1936 TIME OF DEATH: 10:00 AM		DECEASED AT: BALTIMORE, MARYLAND PLACE OF DEATH: BALTIMORE, MARYLAND DATE OF DEATH: 11-11-1936 TIME OF DEATH: 10:00 AM	

DR. W. A. VAN COTT BALTIMORE, MARYLAND		DR. W. A. VAN COTT BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05303

05298

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARRICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS 1404 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print) First LOUISE Middle E. Last PORTMESS		4. DATE OF DEATH Month MAY Day 29 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1883
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (County & State, or foreign country) ONTARIO, CANADA
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN MC KENZIE	
14. MOTHER'S MAIDEN NAME LOUISE FIELDS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (a), stating the underlying cause last. (c) Advanced Age		INTERVAL BETWEEN ONSET AND DEATH 2 wks yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10:10 P.M. 1954 to May , 19 62 , that (I) (we) last saw the deceased alive on 5/29/62 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 6/4/62	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-1-62	
23c. NAME OF CEMETERY OR CREMATORY Lybarger Cem.		23d. LOCATION (City, town or county) (State) Buffalo Mill Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR 5 '62	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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CUMBERLAND

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CUMBERLAND

MEMORIAL & HOSPITAL

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2-11-1883

WHITE

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CUMBERLAND

LOUIS FIELD

JOHN MC KENZIE

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10:10 A.M.

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R. C. O. HINCHMAN

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James

1883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item 8 Film G313 5/21/62 iwk													
1. PLACE OF DEATH a. COUNTY ALLEGANY				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 14 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WEST VIRGINIA				b. COUNTY MINERAL					
3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA BELLE RATCLIFF				4. DATE OF DEATH Month Day Year MAY 10 19 62				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 28, 1884 1883 78		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIRSH RIGGLEMAN				14. MOTHER'S MAIDEN NAME MILLIE KESNER				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic cardiac 4221 DUE TO vasculardis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH March 49					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 5-2-1962		20g. (County) 5-10-1962			
21. I certify that (I) (this hospital) attended the deceased from 5-2-1962 to 5-10-1962 that (I) (we) last saw the deceased alive on 5-10-1962 and that death occurred at 11:20 P.M. from the causes and on the date stated above.													
22a. SIGNATURE W.F. Williams M.D.				22b. DATE SIGNED 5-12-62				22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS				22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/13/62		23c. NAME OF CEMETERY OR CREMATORY Chaneyville Cemetery				23d. LOCATION (City, town or county) (State) Chaneyville, Pennsylvania			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR MAY 16 62				25b. REGISTRAR'S SIGNATURE Arthur S. Harris					

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COUNTY

BARBERS

IN DAYS

MEMORIAL HOSPITAL

STATION

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WINTER'S BELL

FRANK WHITE

JULY 25, 1911

HOUSE

WEST VIRGINIA

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MEMORIAL HOSPITAL - BARBERS

DR. J. F. WILLIAMS

122 S. CENTRAL ST.

John A. Baker, Cumberland, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05303

05300

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN IS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 107 Elder Street		d. STREET ADDRESS 107 Elder Street	
3. NAME OF DECEASED (Type or print) Thomas Walter Reckley		4. DATE OF DEATH May 26 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1877
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (County & State, or foreign country) Kifer, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles M. Reckley		14. MOTHER'S MAIDEN NAME Margaret Raab	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 705-07-6893	
17. INFORMANT Mr. Walter A. Reckley, 107 Elder St. Cumb, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) arteriosclerosis of coronary vessels (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) carcinoma of recto sigmoid junction			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4- 19 59 to 5-26- 19 62 , that (I) (we) last saw the deceased alive on 5-18- 19 62 , and that death occurred at 7:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Lewis Brings		22b. DATE SIGNED May 28, 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Lewis Brings		22d. ADDRESS 57 Greene St. Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1962	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR MAY 31 1962	
25b. REGISTRAR'S SIGNATURE William S. Hanna		DATE	

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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05308 05301											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage				c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) HOWARD THOMAS RICE						4. DATE OF DEATH Month May Day 6 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 29, 1922		9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Allegany Ballistics Laboratory				10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Rice						14. MOTHER'S MAIDEN NAME Emma Crawford					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW2 42-45						16. SOCIAL SECURITY NO. 218-12-5746					
17. INFORMANT Mrs. Howard Rice, Mt. Savage, Md.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } CORONARY SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH SUDDEN --											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DATE SIGNED May 6, 1962					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF May 9, 1962		22c. NAME OF CEMETERY OR CREMATORY St. George Episcopal		22d. LOCATION (City, town, or country) (State) Cty. Mt. Savage, Md.	
23. FUNERAL DIRECTOR Harvey H. Zeigler						ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR MAY 11 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05302

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART		e. STREET ADDRESS 404 WASHINGTON ST		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLET		First Middle Last RICHMOND		4. DATE OF DEATH May 17 19 62	
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9. AGE (In years last birthday) 82		10. DATE OF BIRTH 8-10-79	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BENJAMIN A RICHMOND	
14. MOTHER'S MAIDEN NAME Crissie Sims		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mae Washington		Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) heart cancer 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland		20g. (County) Cumberland		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from June 23, 1961 to May 17, 1962 , that (I) (we) last saw the deceased alive on May 16, 1962 and that death occurred at 130 A.M. from the causes and on the date stated above.					
22a. SIGNATURE L. Brings		M.D. DR. L. BRINGS		22b. DATE SIGNED 5/18/62	
22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS		22d. ADDRESS 57 GREENE ST. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town or county) Cumberland, Maryland		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAY 21 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Francis					

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1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 should be executed and the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

05308

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05303

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN IL LIFETIME		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 32 FROSTBURG		d. STREET ADDRESS 65 E. MAIN STREET	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 214 W. MAIN STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last RIZER				4. DATE OF DEATH Month MAY Day 8TH Year 19 62			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23rd, 1905	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSEWORK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS EISENTROUT				14. MOTHER'S MAIDEN NAME MARGARET LASHBAUGH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-44-0100		17. INFORMANT Address 214 W. MAIN ST., MRS. MARSHALL CATON, JR., FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY Embolism, Massive 460X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mural Thrombus, Right Auricle (c) Varicosities of Lower Extremities						INTERVAL BETWEEN ONSET AND DEATH Sudden Weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) FROSTBURG, MD.							
ACTUAL SIGNATURE W. O. McLane		M.D. ast		DATE SIGNED May 8 1962		EXAMINER'S NAME (Type) W. O. McLane	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-10-62		22c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		22d. LOCATION (City, town, or country) (State) FROSTBURG, MD.	
23. FUNERAL DIRECTOR J. R. Dursst				ADDRESS FROSTBURG, MD.		24a. REC'D BY REGISTRAR MAY 11 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

00308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Pulmonary embolism, massive
thrombus, right dorsal
arteries of lower extremities

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
05309					05304					
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02			d. STREET ADDRESS 247 Virginia Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Dorothy E. Robertson					4. DATE OF DEATH Month May Day 18 , Year 19 62					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1919		9. AGE (In years last birthday) 42 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles H. Smith					14. MOTHER'S MAIDEN NAME Mable V. Cage					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-1413		17. INFORMANT Address Mrs. Donald O. Shoemaker Oldtown, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X FRACTURE OF CERVICAL VERTEBRAE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (Automobile Accident) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 42 Min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Head On Automobile Collision							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 12:15 May 18 19 62			20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. # 51 3.5 Mi. East of Cumberland, Md.		20f. (City or town) Allegany (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Benedict Skitarelic					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 5-21-62		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or country) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR Scarpelli Funeral Home Cumberland, Md.					24a. REC'D BY REGISTRAR DATE MAY 22 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 704 BROOKFIELD AVE., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELTA Middle E. Last SHEAKLEY			4. DATE OF DEATH Month MAY Day 17 Year 19 62				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28, 1887	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria Worker		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) OHIO Wellston		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK J. PITTENGER			14. MOTHER'S MAIDEN NAME SARAH KINNISON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-0581		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) myocarditis - Decomposition (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs 1 yr	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 0 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 1, 1962 to May 17, 1962 that (I) (we) last saw the deceased alive on May 17, 1962, and that death occurred May 25, 1962 at 2:00 A.M., from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett M.D.			22b. DATE SIGNED 5/18/62				
22c. PHYSICIAN'S NAME (Type) CLAY E. DURRETT			22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-62		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, d.	
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			25a. REC'D BY REGISTRAR MAY 22 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05311

05306

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania COUNTY Bedford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY in 1b minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buffalo Mills Rural 75x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS RD#1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle W. Last Shoup				4. DATE OF DEATH Month May Day 31 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1912	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS. Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer on B&O			10b. KIND OF BUSINESS OR INDUSTRY Hyndman, Pa.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Luther Shoup				14. MOTHER'S MAIDEN NAME Cora Lybarger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-6057		17. INFORMANT Address RD#1 Mrs. Cora Shoup Burrall Mills, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO possible coronary thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) chronic coronary artery disease with insufficiency. (c) with insufficiency.				INTERVAL BETWEEN ONSET AND DEATH possibly 20 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 4-11-1958 to 12-31-1962 , that (I) (we) last saw the deceased alive on 5-31-62 , and that death occurred at 12-31-62 from the causes and on the date stated above.							
22a. SIGNATURE John A. Topper M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6-1-62			
22c. PHYSICIAN'S NAME (Type) John A. Topper M.D.			22d. ADDRESS Hyndman, Pa.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4, 1962	23c. NAME OF CEMETERY OR CREMATORY Lybarger Cemetery		23d. LOCATION (City, town or county) (State) Buffalo Mills RD#1 Pa.		
24. FUNERAL DIRECTOR'S SIGNATURE Harvey N. Feigler			ADDRESS Hyndman, Pa.	25a. REC'D BY REGISTRAR JUN 5 '62			
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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CLASSIFIED BY 10-10-10

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10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05312 CERTIFICATE OF DEATH 05307											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 62 Cumberland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 821 Buckingham Road, Dingle						d. STREET ADDRESS 821 Buckingham Rd. Dingle					
3. NAME OF DECEASED (Type or print) First Duncan Middle Lindley Last Sloan						4. DATE OF DEATH Month May Day 13 Year 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1874		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Judge				10b. KIND OF BUSINESS OR INDUSTRY Attorney at Law				11. BIRTHPLACE (County & State, or foreign country) Pekin, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James M. Sloan						14. MOTHER'S MAIDEN NAME Ella Frederick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)						16. SOCIAL SECURITY NO. NONE					
17. INFORMANT Mrs. D. Lindley Sloan 821 Buckingham Rd.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of neck, primary 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Site undetermined (Rt.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1952 to 5/13/62 , that (I) (we) last saw the deceased alive on May 12 1962 , and that death occurred at 1:35 P.M. from the causes and on the date stated above. 22a. SIGNATURE SG Weisman M.D. 22c. PHYSICIAN'S NAME (Type) SG WEISMAN MD 22b. DATE SIGNED 5/14/62 MD 22d. ADDRESS 59 GREENE ST CUMBERLAND 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/15/62 23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park 23d. LOCATION (City, town or county) (State) Frostburg, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer Cumberland, Maryland ADDRESS 25a. REC'D BY REGISTRAR MAY 16 '62 DATE 25b. REGISTRAR'S SIGNATURE Arthur L. Hines											



02313

05303



John A. Hays, Cumberland, Maryland
Witness: [illegible]
[illegible]

Testimony: [illegible]

[Extremely faint and mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Witness", "Testimony", and "John A. Hays" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

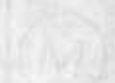
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05313 CERTIFICATE OF DEATH 05308											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY in lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE,				d. STREET ADDRESS DUTCH HOLLOW	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last SHIRLEY J. SMITH						4. DATE OF DEATH Month Day Year MAY 21ST, 19 62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 24TH, 1926		9. AGE (In years last birthday) 35 Yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Opr. Service Dept.				10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME NORMAN MILLER						14. MOTHER'S MAIDEN NAME PAULINE BEVER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 204.3				16. SOCIAL SECURITY NO. 218-24-8007		17. INFORMANT Address ERNEST P. SMITH, MT. SAVAGE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 weeks											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) MT. SAVAGE,		20g. (County) ALLEGANY		20h. (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from May 9, 1962 to May 21, 1962 , that (I) (we) last saw the deceased alive on May 21, 1962 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE W. O. McLane M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 22 1962			
22c. PHYSICIAN'S NAME (Type) W. O. McLane,						22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-24-62		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S CEMETERY		23d. LOCATION (City, town or county) MT. SAVAGE,		23e. (State) MD.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst ADDRESS FROSTBURG, MD.						25a. REC'D BY REGISTRAR DATE MAY 28 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/17/58	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 211 North Lee St.,	
3. NAME OF DECEASED (Type or print) First Middle Last George A. Stuiber		4. DATE OF DEATH Month Day Year May 29 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1887
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Stuiber		14. MOTHER'S MAIDEN NAME Wilhelmina Guisiga	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Address Allegany County Infirmary, Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) ① Coronary Thrombosis ② Arterio-sclerosis general ③ Cerebral apoplexy of Rt. Hemisphere			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/17/58 , 19....., to 5/29/62 , 19....., that (I) (we) last saw the deceased alive on 5/29/62 , 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 5/29/62	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/62	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Ph.	23d. LOCATION (City, town or county) (State) Cumberland Md
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md		25a. REC'D BY REGISTRAR MAY 31 62	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05315

05310

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY																					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN hb 17 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG,		d. STREET ADDRESS 1 204 GLENN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First WILBUR Middle TAYLOR Last TAYLOR				4. DATE OF DEATH Month MAY Day 11TH Year 19 62																					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 6TH, 1894		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME FREDERICK TAYLOR				14. MOTHER'S MAIDEN NAME LUCINDA RECTOR				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address MRS. ELLEN WELLINGS, 204 GLENN ST., F'BG. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of Colon DUE TO (c) 2 mo												INTERVAL BETWEEN ONSET AND DEATH 1 Day													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)													
21. I certify that (I) (this hospital) attended the deceased from Apr 24, 1962 to May 11, 1962 , that (I) (we) last saw the deceased alive on May 11, 1962 , and that death occurred at 11 PM , from the causes and on the date stated above.																									
22a. SIGNATURE WOMc Lane M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED May 12 1962																	
22c. PHYSICIAN'S NAME (Type) WOMc Lane MD				22d. ADDRESS Frostburg MD																					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 5-14-62		23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK				23d. LOCATION (City, town or county) FROSTBURG, MD.															
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				ADDRESS FROSTBURG, MD.				25a. REC'D BY REGISTRAR DATE MAY 16 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Hume													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The fee 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05316

CERTIFICATE OF DEATH

05311

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if in hospital, give street address) MEMORIAL & WARWICK AVE. MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 2 GRAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELIA G. VAN METER		4. DATE OF DEATH Month Day Year MAY 13 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1895
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) KEYSER KEYSER, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ANTHONY REED		14. MOTHER'S MAIDEN NAME MARY WATSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhages 331X DUE TO (b) Essential Hypertensive Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus			
INTERVAL BETWEEN ONSET AND DEATH Unk			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12 May 1962 6:15 P.M. to 13 May 1962 that (I) (we) last saw the deceased alive on 13 May 1962 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. L. MICHAEL GLICK		22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 16, 1962	23c. NAME OF CEMETERY OR CREMATORY QUEENS POINT CEMETERY	23d. LOCATION (City, town or county) (State) KEYSER, W. VA.
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR DATE JUN 6 '62	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

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OF THE CASE OF DEATH

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GENERAL HOSPITAL - GREEN HOSPITAL

DR. L. J. MICHAEL RICH

DR. L. J. MICHAEL RICH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral-director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 9/60

MAY 3 1962									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b Maryland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Memorial Hosp.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings, d. STREET ADDRESS Along U. S. Rt. # 220 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ELLIS Middle PORTER Last WARNICK					4. DATE OF DEATH Month May Day 1, Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1899		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenters Hlpr.		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) New Germany, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Horace R. Warnick					14. MOTHER'S MAIDEN NAME Ellen J. Custer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 217-10-4961		17. INFORMANT Address Mrs. Wilda S. Warnick Rawlings, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, 420.1 DUE TO CORONARY SCLEROSIS, Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH SUDDEN -----									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> May 2, 1962 DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER KX Rt. # 9 Cumberland, Md. Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/62		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park, Cumberland, Maryland		22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.					24a. REC'D BY REGISTRAR DATE MAY 3 '62		24b. REGISTRAR'S SIGNATURE Charles L. George		

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James H. George
11/1/51
11/1/51
11/1/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05318 CERTIFICATE OF DEATH 05313											
1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG,				d. STREET ADDRESS 1 183 E. MAIN ST.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ea RASTUS						First WEICHT Last WEICHT		4. DATE OF DEATH Month MAY Day 13TH Year 19 62			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH JUNE 2ND, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. MINER				10b. KIND OF BUSINESS OR INDUSTRY COAL MINING		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN C. WEICHT						14. MOTHER'S MAIDEN NAME ALICE CORNELL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO. 215-10-8002		17. INFORMANT CHARLES WEICHT, WESTERNPORT, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic Cardio vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-11 1962 to 5-13 1962 that (I) (we) last saw the deceased alive on 5-13 1962 , and that death occurred at 10 PM , from the causes and on the date stated above.											
22a. SIGNATURE H. C. Diehl						M.D. "		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/14/62	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL						22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/62		23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery				23d. LOCATION (City, town or county) (State) Clearville, Bedford- Penn			
24 FUNERAL DIRECTOR'S SIGNATURE El. Boal - Westernport, Md						ADDRESS		25a. REC'D BY REGISTRAR MAY 15 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05319

05314

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital (D.O.A.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Angela Wilk		4. DATE OF DEATH Month May Day 15 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) yrs. 62 68
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McDonough		14. MOTHER'S MAIDEN NAME Frances Farrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-22-2893	
17. INFORMANT Mrs. Patrick R. McGeady		Address 303 Decatur Street Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY SCLEROSIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/62	
22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR Ruth E. Silcox		24a. REC'D BY REGISTRAR MAY 18 1962	
ADDRESS Cumberland Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

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ORDINARY 001 2000

ORDINARY 001 2000

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XX Nov 1, 1962

THE EDITOR AND PUBLISHER

SALES

Subscription Department

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05320						05315					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)					
a. COUNTY Allegany						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg						b. COUNTY Allegany					
c. LENGTH OF STAY IN 1b 5 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital						d. STREET ADDRESS 1					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED						4. DATE OF DEATH					
(Type or print)						(Month Day Year)					
THOMAS ROBERT WILLISON						5 10 1962					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-07		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Automobile				11. BIRTHPLACE (County & State, or foreign country) Eckhart, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas W. Willison				14. MOTHER'S MAIDEN NAME Lillie Twigg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-07-7298				17. INFORMANT Edith Beltz Willison, Eckhart, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis				(b) myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 5 days 7			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								several months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from April 28, 1962 to May 11, 1962 , that (I) (we) last saw the deceased alive on May 11, 1962 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE WOM Lane M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED May 12 1962		
22c. PHYSICIAN'S NAME (Type) WOM Lane						22d. ADDRESS Frostburg Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-62		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery				23d. LOCATION (City, town or county) Eckhart, Md. (State)			
24 FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home						25a. REC'D BY REGISTRAR DATE MAY 17 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

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Library

Library

Thomas Hospital

Robert

1978

William

Robert

Thomas

1978

Anderson

Anderson

William

Thomas

1978-1979

None



1978-1979

William

Thomas

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05321 CERTIFICATE OF DEATH 05316

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN It <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>306 BEALLEX STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A</u> Last <u>WOLFE</u> DATE OF DEATH <u>MAY 25 1962</u>				9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>AUG 7, 1886</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>	
13. FATHER'S NAME <u>GEORGE A KNOUSE</u>				14. MOTHER'S MAIDEN NAME <u>Alene Miltenberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>CHART</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> , primary Right Breast 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> 19 <u>62</u> to <u>5/25</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> 19 <u>65</u> , and that death occurred at <u>6:15 A</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo Ley</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. LEO LEY</u>				22d. ADDRESS <u>456 N. CENTER STREET</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>5-28-62</u>		<u>St. Peter & Paul Cem. Cumberland, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli Cumberland, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 31 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after the date of death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after the date of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03310

CENTROPEDE DE BATH

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